BHSF Form 2(MB)
Rev. 03/05
Prior Issue Obsolete
II

Renewal Due:_____

CSLD/WKR:_____

Medicare Savings Program
Renewal Form

This form is used to continue getting Medicaid payment for certain Medicare costs, such as the premiums, coinsurance, and deductibles. If you need help filling out this form call your local Medicaid office or call us toll free at 1-888-342-6207. If you are deaf or have hearing problems call the TTY number at 1-800-220-5404. You may call your local Medicaid Office to answer the questions on this form over the phone. If you want to apply for other health coverage (such as nursing facility, waiver services, or Medically Needy coverage), mark (x) this box (❑). We will send you information about applying for other coverage and tell you what you have to do to protect your application date.

What language do you speak best? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other (specify)_____
What language do you write best? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other (specify) _____

"We can provide an interpreter at no cost to you, if you do not speak English."

1. Tell us about the person who gets help:

Name (First, Middle Initial, Last) _____
Mailing Address_____ City_____State____ Zip Code_____
Home Address_____ City_____State____ Zip Code_____
Parish_____ Home Phone # (___)_____ Daytime Phone # (___)_____

2. Have there been any changes in the family members living in your home since your last application or renewal? ❑ No ❑ Yes (If **No, go to** Question 3.)

Tell us about the new family members who have moved into your home. Also show spouse and any children under age 18. You do not have to give Social Security numbers for those who are not applying. If you do, they will only be used to verify income.

Name - first, middle initial, last (**If** applying, mark (x) the ❑)	Relation to You (husband, wife, etc.)	Social Security Number	Date of Birth month/ day/ year	U.S. Citizen	Does this person have Medicare?
❑				❑ Yes ❑ No	❑ Yes ❑ No
❑				❑ Yes ❑ No	❑ Yes ❑ No

Tell us the name of any family members who have moved out or no longer live in your home since your last application or renewal? _____

3. Do you still have Medicare? ❑ Yes ❑ No If **No**, tell us when you lost Medicare. _____
Give us the name(s) of anyone else living in your home who has Medicare._____

4. Do you or anyone applying have private health insurance that covers doctor and hospital visits? ❑ Yes ❑ No If **Yes**, answer the following. (Send proof of coverage.)

Insurance Company Name, Address, & Phone	Group/Policy Number	Person(s) Covered	Policy Covers: (✓)		
			hospital	doctor	ambulance
			maternity	drugs	dental

5. Does anyone work or is self-employed? ❑ Yes ❑ No If **Yes**, tell us about **each** full-time job, part-time job, or business. Show gross income before any deductions - **not** take-home pay.
(For **each** job, send copies of **all pay check stubs** or other proof of earnings for last month. For self-employment, send copies of the most recent federal tax form with **all** schedule attachments, or other proof if you do not have tax forms.)

A. Give us the name, address, & phone # of the company or person you work for **or** B. Self-employment information	Name of the Person Working	Amount Paid Per Hour	Number of Hours Worked/Week	How often paid?
		$		
		$		

6. Tell us about anyone getting **any** other money, like the kinds listed below. (Send proof of the income that is received. You **do not** have to send proof of Social Security/SSI income or Unemployment Compensation.)

Types of Income	Source Name, Address, & Phone	Who gets this money?	How much?	How often?
Social Security/SSI ❑ Yes ❑ No			$	
Retirement/Pension/Annuities/ Veteran's Benefits ❑ Yes ❑ No			$	
Interest/Dividends/Royalties ❑ Yes ❑ No			$	
Money from friends/relatives ❑ Yes ❑ No			$	
Other (unemployment compensation, rental income, workman's comp, etc.) ❑ Yes ❑ No			$	

Has anyone applied for but not yet received money from any of these sources? ❑ Yes ❑ No
If **Yes**, who and from what source? _____

7. Tell us about anyone having **any** of the things listed below. (Send proof of ownership and the value of each.)

Item (resource or asset)	Company Name, Address, & Phone; Account/Policy Number; and/or Description	To whom does this belong?	Bank Account Balance	Value	Amount Owed
Bank Accounts ❑ Yes ❑ No			$		$
Stocks/Bonds/Trust Funds ❑ Yes ❑ No				$	$
Property other than your home ❑ Yes ❑ No				$	$
Life/Burial insurance ❑ Yes ❑ No				$	$
Funeral/Burial Plans (bank account, pre-need, burial contract with funeral home, etc.) ❑ Yes ❑ No			$	$	$
Vehicles (make, model, year) ❑ Yes ❑ No				$	$
Other (CDs, Mineral Rights, IRAs, etc.) ❑ Yes ❑ No			$	$	$

_____ _____
Signature of Applicant or Authorized Representative Date

_____ _____
Signature of Spouse, if applicable Date

_____ _____
Signature of Agency or AC Representative, if applicable Date